Magnolia Medical Clinic, P.A.
131 Magnolia Avenue SE
Fort Walton Beach, FL 32548

Patient Information

Date___________________

Patient's Name ______________________________________
Date of Birth ________________ Sex: ❑ Male ❑ Female
Social Security Number ______-______-___________
Marital Status: Single Married Divorced Widowed
Race ______________________________________
Ethnicity: ❑ Latino/Hispanic ❑ Not Hispanic/Latino ❑ Other
Street Address______________________________________
City ____________________ St. _____ Zip ___________
Home phone (_______) ______________________________
Cell phone (_______) ______________________________
Email ______________________________________
Preferred method of communication:
❑ Text ❑ Email ❑ Call - ❑ Home ❑ Cell ❑ Work

Employer ______________________________________
Street Address______________________________________
City ____________________ St. ____ Zip ___________
Phone (______) ______________________________
Occupation ______________________________________
Emergency Contact Name _________________________
Phone (_____) ______________________________
Relation to contact ______________________________

Primary Physician: Dr. Buckelew Dr. Pappas
Dr. Senechal Dr. Sites

Referred by: ______________________________

Guarantor (responsible party for bill)

Name ______________________________________
Mail Address ______________________________________
City ________________ St. _______ Zip ______________
Phone – Home (____) ____________ Cell (____) __________
Relationship to patient __________ DOB ______________

Social Security _________-______-______________
Employer ______________________________________
Address ______________________________________
City ________________________ St. ____ Zip __________
Phone (_____) ______________________________

Nearest Relative (Outside Household)

Name ______________________________________
Mail Address ______________________________________
City ________________ St. _______ Zip ______________

Phone (_____) ______________________________
Relationship to patient______________________________

Medical Insurance

Primary Insurance
Company Name ______________________________
Mail Address ______________________________
City ________________ St. _______ Zip ______________
Phone (_______) ______________________________
Insured/Subscriber Name ______________________
Insured/Subscriber DOB ______________________
Relationship to patient ______________________
Policy Number ______________________________
Group ______________________________________
Effective Dates _____________ to ___________________

Secondary Insurance
Company Name ______________________________
Mail Address ______________________________
City ________________________ St. ____ Zip __________
Phone (_____) ______________________________
Insured/Subscriber Name ______________________
Insured/Subscriber DOB ______________________
Relationship to patient ______________________
Policy Number ______________________________
Group ______________________________________
Effective Dates ______________ to __________________

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Insurance Assignment and Authorization Form

Magnolia Medical Clinic, P.A. is pleased to file insurance for our patients. In order to process your insurance claims, the patient or responsible party is responsible for providing the most current address, phone number, and insurance information at the time of service.

_____ I authorize payment directly to Magnolia Medical Clinic, P.A. of insurance benefits that may be otherwise payable to me by my insurance company (ies). I hereby transfer to Magnolia Medical Clinic, P.A. my right to payment from any insurance company (ies) that is/are responsible for my charges on this account.

Statement of Financial Responsibility

_____ I acknowledge that I am responsible for all charges for Magnolia Medical Clinic, P.A. services provided to me, whether insured in the past or future, including any amount not paid and/or not covered by insurance or other third party payers, excluding contractual insurance adjustments. I understand that Magnolia Medical Clinic, P.A. will not accept responsibility for collecting insurance or negotiating the settlement of a disputed insurance claim. I agree to pay the charges for care provided to the patient by Magnolia Medical Clinic, P.A. at time of service. Should collection action become necessary, I agree to pay reasonable attorney fees, expenses and court costs incurred by Magnolia Medical Clinic, P.A.

_____ I have read and understand the terms stated above. The terms and conditions constitute my complete agreement and may be modified only by written agreement signed by an authorized official of Magnolia Medical Clinic, P.A. I acknowledge receipt of a copy of this agreement.

Medicare Patients

_____ I request that payment of authorized Medicare benefits be made either to me or on my behalf to Magnolia Medical Clinic, P.A. for any service furnished to me by physicians of Magnolia Medical Clinic, P.A.. I authorize release to the Centers for Medicare and Medicaid Services and its agents any medical information about me needed to determine payments for related services.

I, the undersigned, certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. I give my consent to Magnolia Medical Clinic, P.A. to use and disclose information about me for the purposes described in this form. I understand that I can withdraw this consent, in writing at any time except where you have already used or disclosed information in reliance on my prior consent.

____ _______________________
Patient Name Date of Birth

____ _______________________
Signature Date
*If patient is under 18 or unable to sign, representative must sign below.

*Reason for representative signature:
❑ Patient under 18 ❑ Physical disability ❑ Other: ______________________________

_______________________________________ _______________________________________
Representative Name Relationship to patient

____
Representative Address

____ _______________________
Representative Signature Date

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Authorization for Disclosure of Health Information

Patient's Name: ____________________

Date of Birth: ____________________ Phone: (______) ____________________

Address: ____________________

City: ____________________ State: __________ Zip: ____________________

1. I authorize the use of disclosure of the above named individual's health information as described below.
2. The following organization is authorized to make the disclosure:

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3. The type and amount of information to be used or disclosed is as follows: (include dates when appropriate)

_____ Complete health records _____ Lab results/X-ray reports
_____ Physical Exam _____ Consultation reports
_____ Immunization Record
_____ Other (please specify): ____________________

____

4. I understand that the above information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Name: ____________________ DOB: __________ Name: ____________________ DOB: __________
Name: ____________________ DOB: __________ Name: ____________________ DOB: __________
Name: ____________________ DOB: __________ Name: ____________________ DOB: __________
Name: ____________________ DOB: __________ Name: ____________________ DOB: __________

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

____

7. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date unless renewed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:
Sandy Johnson, Privacy Officer for Magnolia Medical Clinic, P.A.

____________________ ____________________
Signature of patient or legal representative Signature of witness

Date: ____________________ Date: ____________________

RENEWAL INFORMATION

Date	Signature	Witness	Date

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ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I acknowledge that I have received a Notice of Privacy Policy from the above names Practice. **
You May Refuse to Sign This Acknowledgment

Patient Name (Please PRINT): ____

Signature: ____

Date: ____________________________

Witness: ____

I am a personal representative/parent (please circle one) for the following patient and/or patients in this practice. I acknowledge that the Notice of Privacy Policies that I received is for the following: (List First and Last Name and Date of Birth)

1. ____ ___________
2. ____ ___________
3. ____ ___________
4. ____ ___________
5. ____ ___________

Name (Please PRINT): ____

Signature: ____

Date: _____________

Witness: ____

FOR OFFICE USE ONLY

We attempted, in good faith, to obtain written acknowledgement of receipt of our Privacy Policy, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgment
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please explain below)

____
____
____
____

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Appointment Reminders

After your appointment is scheduled, a representative from Magnolia Medical Clinic (MMC) will hone you two (2) days prior to your appointment to remind you of your appointment. Although we make every effort to speak with you, we might be required to leave a message. If you are unable to keep your appointment, please notify our office at least 24 hours in advance at (850) 243-7681 to reschedule. Multiple no shows can and will lead to your dismissal.

Checking In

Please arrive at least 15 minutes early for physician visits. Upon arrival, please place your name on the Sign-In Sheet. A patient services representative will request to see your insurance cared and may request a photo ID. They will scan your insurance cad and verify with you that all information in the computer is accurate. They will then have you complete any necessary forms. **They will also collect your co-payment and any outstanding balance.**

Delays

On occasion, our Physicians may need to spend a little more time with a patient than anticipated. The nature of our practice is to give our patients the utmost care and service. Please excuse any delays. We will give you the same careful attention as soon as possible.

Laboratory Hours

Scheduled labs 7:30am-10:00am – Coumadin Patients 10:00am-2:00pm – Walk-in labs 10:00am-4:00pm

Medical Records

All medical records are stored at our main office. Any questions regarding medical records and/or requests for copies of your medical records may be addressed by calling our main number at (850) 243-7681. Processing of your request takes approximately 10 business days. Please note there is a fee for some services.

Medical Records Authorization

Protected Health Information (PHI) will only be released from our practice with a properly executed authorization from the patient or his/her personal representative, unless specifically excluded under the Health Insurance Portability and Accountability Act (HIPAA). Please ask any patient services representative for the Authorization for Disclosure of Health Information (Blue Form).

Radiology

All x-ray films are stored at our main office. Any questions regarding x-rays may be addressed by calling our main number at (850) 243-7681.

Treatment of Minors

A parent or legal guardian must accompany new patients under the age of 18 at their initial visit. The parent or legal guardian may designate someone to accompany an existing patient during follow-up visits if it is specified on a Minor's Consent for Treatment form. This form can be obtained at the check-in area.

Prescriptions

Please contact your Pharmacy for all of your prescription refills. We require 72 hours to process your requests. If your Pharmacy has not notified you that your refill is ready after 72 hours, please contact us during the normal business hours of 8:00am – 5:00pm, Monday through Friday. Prescription refills are not considered an emergency and cannot be left with our answering service.